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ABSTRACT

Since its creation in 1997, the State Children's Health Insurance Program (SCHIP) has provided low-income children the access to health care they desperately need. Recognizing the important role health insurance plays in assuring that children come to school healthy and ready to learn, the Council of Chief State School Officers (CCSCO) gathered information from its member state education agencies (SEA) and the state agencies charged with oversight of the Medicaid programs. Interviews were completed with 27 SEA personnel and 20 staff from state Medicaid agencies, with 35 states represented. The CCSCO also convened an advisory group of representatives of key national organizations involved in governance and outreach for Medicaid and SCHIP; this group reviewed preliminary findings and discussed possible strategies for strengthening school-based outreach and enrollment efforts. Findings revealed that states enlist a variety of strategies to extend the reach of the SCHIP and Medicaid programs. Linking outreach to the school-based nutrition programs was the most common outreach tool. School nurses played a key role in school-based activities for SCHIP and Medicaid. Several barriers to successful and consistent implementation of outreach strategies were noted, including the lack of statewide systemic school-based infrastructure for disseminating and collecting information on SCHIP and Medicaid, inconsistent involvement in programs at the local level, and the need for a common language linking the education and health domains. States have enlisted a number of strategies to overcome these barriers, the most important being collaborating with agency personnel. A call to action was devised to strengthen and institutionalize school-based outreach and enrollment for SCHIP and Medicaid. (A list of the participating states and members of the advisory group is appended.) (KB)

BUILDING BRIDGES TO HEALTHY KIDS AND BETTER STUDENTS

**School-based Outreach and Enrollment
for the
State Children's Health Insurance
Program and Medicaid**

**A View from the States
December 2001**

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The Council of Chief State School Officers (CCSSO) is a nationwide nonprofit organization of the public officials who head departments of elementary and secondary education in the states, the District of Columbia, the Department of Defense Education Activity, and five extra-state jurisdictions. CCSSO seeks its members' consensus on major educational issues and expresses their views to civic and professional organizations, to federal agencies, to Congress, and to the public. Through its structure of standing and special committees, the Council responds to a broad range of concerns about education and provides leadership on major education issues.

RESOURCE CENTER ON EDUCATIONAL EQUITY

The CCSSO Resource Center on Educational Equity provides services designed to achieve equity and high-quality education for minorities, women and girls, the disabled, limited-English proficient, and low-income students. The Center is responsible for managing and staffing a variety of CCSSO leadership initiatives to ensure educational success for all children and youth, especially those placed at risk.

HIV/SCHOOL HEALTH PROJECT

The HIV/School Health Project assists state education agencies in promoting and supporting a coordinated approach to school health. Current activities include producing and disseminating materials that chief state school officers, state health officials, their staff, and other interested colleagues can use to engage the public concerning the importance of taking a coordinated approach to school health. The project assists state education agencies to strengthen their capacity to support school-linked approaches to preventing teen pregnancy and to assure that effective HIV prevention programs are targeted to young people who are disproportionately at risk for contracting HIV. The project also produces the Directory of Coordinated School Health Program Staff. The Council also operates the Comprehensive

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SUMMARY

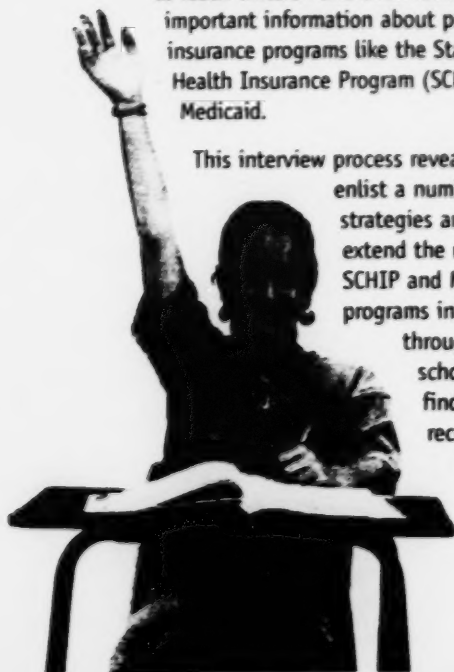
 The link between children's health and their potential to succeed in school is inextricable. U.S. Secretary of Health and Human Services Tommy G. Thompson underscored this connection while addressing the White House Summit on Early Cognitive Development when he said, "Health care belongs at the heart of a comprehensive approach toward early [learning.] One of the best ways we can foster a child's cognitive development is to make certain that child has access to medical care."

The Council of Chief State School Officers, through an extensive interview process conducted with state education and Medicaid personnel, found that agency staff who oversee school-based outreach and enrollment for their state public health insurance programs also agree with the premise. They extend the connection further by promoting the fact that since schools are where children spend the majority of their days, they are a natural place to reach children and their families with important information about public health insurance programs like the State Children's Health Insurance Program (SCHIP) and Medicaid.

This interview process revealed states enlist a number of strategies and tactics to extend the reach of the SCHIP and Medicaid programs into and throughout their schools. CCSSO's findings and recommendations include the following:



- 1 States have used a wide variety of materials and media to disseminate messages about health insurance to families. Schools, as a trusted source of information, are often asked to participate in the process. Too often, though, schools are merely asked to disseminate materials and are not able or willing to assist families with the follow-through necessary to ensure enrollment.
- 2 The School Lunch Program has been used in many states and districts as a source of information for families and for outreach workers seeking to identify eligible families. Here too, information is often collected without capacity for reasonable follow-through.
- 3 School nurses are key participants in school-based outreach and enrollment efforts. Through their contact with families and school staff such as athletic directors, they can play a pivotal role in outreach and enrollment. School nurses hold a particular place of trust among parents and families.
- 4 Despite a clear understanding among interviewees of the importance of school-based outreach and enrollment, challenges still exist. At the root of many of these challenges are the differing cultures and "languages" of education and health. Better communication, cooperation, and collaboration between the key state agencies can do much to help those "on the ground" overcome the challenges. In addition, it is critical to involve the professional associations representing these people.

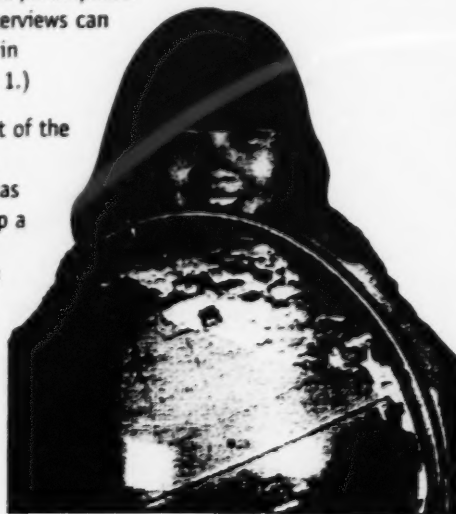


INTRODUCTION

Since its creation in the federal budget negotiations of 1997, the State Children's Health Insurance Program (SCHIP) has provided low-income children the access to health care they so desperately need. SCHIP has been the "single largest public investment in children's health care since the creation of Medicaid in 1965" (A Golden Opportunity, p. i), expanding health coverage to millions of uninsured children and adolescents across the nation. Schools have been identified as an important component in the efforts to reach the families of eligible children in SCHIP and Medicaid programs.

Recognizing the important role health insurance plays in assuring children come to school healthy and ready to learn, the Council of Chief State School Officers (CCSSO) undertook an information-gathering process among its member state education agencies and the state agencies charged with oversight of the Medicaid programs. This effort was funded through a grant from the David and Lucile Packard Foundation. During the process, 47 half-hour interviews were conducted, representing 35 states. Twenty-seven state education agency personnel and 20 staff from state Medicaid agencies were interviewed. Participants were identified through letters sent to the chief state school officers by Gordon Ambach, at that time Executive Director of CCSSO, and to the heads of the state Medicaid agencies by Lee Partridge, Director of the Health Policy Unit of the American Public Health Services Association. (A list of the states that participated in the interviews can be found in Appendix 1.)

The intent of the interview process was to develop a general picture of current and



planned school-based outreach and enrollment activities in the states; the roles the respective agencies currently hold with respect to SCHIP/Medicaid outreach and enrollment within schools; the existing and planned partnerships the agencies join in their school-based outreach and enrollment efforts; and the successes and barriers to success they have noted to date. State representatives from both agencies were uniformly enthusiastic about the programs and forthcoming about the hurdles they faced.

In addition to the interviews described above, CCSSO convened an advisory group consisting of representatives of key national organizations whose members are involved in governance and outreach for Medicaid and SCHIP. (A full list of the members of the advisory group can be found in Appendix 2.) The advisory group reviewed the preliminary findings from the interviews and discussed possible strategies for strengthening school-based outreach and enrollment efforts.

From these two information-gathering efforts, CCSSO concluded school-based outreach and enrollment are effective strategies and state education agencies can and should play an important role in facilitating those efforts.

OUTREACH MATERIALS AND DISSEMINATION

States make use of an array of media to disseminate messages on their SCHIP and Medicaid programs. These include printed materials such as detailed information brochures (combined or not with actual applications to the programs), slim-jims (two-sided cards that fit directly in an envelope), and smaller bookmarks. Many states print the materials in multiple languages.

Most of the materials are state-specific and are developed, purchased, or obtained by the Medicaid agencies. However, since children and their families are the target audience and children are universally required to be in school, the school is a natural conduit used by states. Common

distribution mechanisms include insertion of printed materials in

"Back to school" packets sent home with children at the beginning of the year

Direct mailings from the school principal to school families

The free and reduced-price school lunch application packet

The school health or immunization status/medical record cards

School, district, or statewide newsletters to parents

Report card envelopes

Kindergarten recruitment mailings

The insurance/participation permission slips distributed to students who are trying out or planning to play for school athletic teams

In addition, materials such as packets, brochures, and slim-jims are made available on information tables and display cases within school offices, libraries, and counselor and nurse offices/health centers.

States also use other more indirect media for conveying information about their SCHIP and Medicaid programs through the schools. These include articles or advertising in state education agency newsletters/newspapers (most of these are distributed statewide to every school family). Articles or advertising are also included in statewide or regional association newsletters that target superintendents, principals, counselors, school nurses, school food service coordinators, athletic directors, and, less frequently, teachers. The objective here is to provide information to school leaders about the program and to enlist their support and partnership in the more direct outreach effort.

Other printed materials include information posters hung in school offices, libraries, gyms, classrooms, and hallways. Several states cite market-tested images and text, sometimes in multiple languages, for reaching varied age groups and types of school



populations. Three of the more rural states said they provide or are planning to provide outreach and application assistance through programming on distance learning systems, e.g., school television programming or web courses.

THE USE OF SCHOOL NUTRITION PROGRAMS

The link between state SCHIP, Medicaid, and the child nutrition programs operated in schools is the most common outreach tool identified by states. Most have taken advantage of the recent rule change by the U.S. Department of Agriculture allowing the use of the application for the department-sponsored Free and Reduced-Price School Breakfast and Lunch Programs. The new regulation permits states to use the school meals application for the collection and sharing of family/student data with other programs serving individuals in poverty. In most states, though not all, the level of poverty required for eligibility for the SCHIP and Medicaid program falls within the range required by the meals program. (A comprehensive study of the use of the school meals programs for SCHIP and Medicaid outreach and enrollment has been conducted by the Center on Budget and Policy Priorities and can be found at www.cbpp.org.)

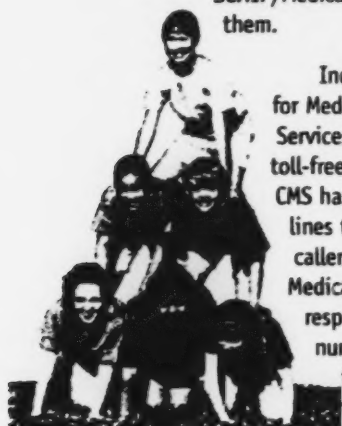
The meals program is employed for SCHIP and Medicaid outreach through a range of activities, including the following:

As noted above, insertion of outreach materials such as brochures or slim-jims within the meal applications sent to every school child in the state. In some cases these packets also include the SCHIP/Medicaid application.

The incorporation of public health insurance information on the school meal application itself. For example, the application may include a brief descriptive paragraph about the state health insurance programs that also highlights contact data on how to obtain further information.

Passive check-off boxes, often introduced by the paragraphs noted above, asking parents if they would like to receive additional information regarding the state's health insurance programs.

Check-off boxes that provide consent to convey and use the information shared within the school lunch forms. State and local Medicaid staff use this consent box to identify students and families potentially eligible for SCHIP/Medicaid and to contact them.



Inclusion of the Centers for Medicare and Medicaid Services (CMS, formerly HCFA) toll-free phone number. The CMS has provided toll-free lines to states linking callers to their state's Medicaid/SCHIP office. State respondents identified this number as the most frequent inclusion on the lunch application.

In a very few states, eligibility for SCHIP is presumed based on family eligibility for the free and reduced-price meals programs. The family is enrolled in SCHIP based on the information provided in the meals program application and notified of the temporary status.

How the information is shared and gathered and with what uniformity will be discussed later in this paper.

SCHOOL NURSES AND HEALTH OFFICES

Respondents believe that school nurses play a key role in school-based activities for SCHIP and Medicaid. Often, the school building nurse is the key representative for the programs within the schools.

One starting place for school nurses is the use of the school health card. All states have immunization requirements for school entry, and

virtually all require periodic health examinations for continued enrollment. Determining the health status of entering kindergartners (or in some cases pre-K students) also falls to the school nurses.

The health card is employed for sharing and obtaining data in similar ways to the school lunch program application, though not so consistently, e.g., the inclusion of SCHIP materials along with the health cards when they are mailed or sent home with students. In a number of cases, SCHIP information or the CMS toll-free number were incorporated directly on the health cards. Health cards also require students to identify health insurance, and this is a natural starting point for identifying children who are not insured.

Because of their central role in determining and monitoring the health status of individual students, school nurses are an important resource for more direct, personal outreach and, in some cases, enrollment. The activities of school nurses include the following:

- The use of the school nurse office/health clinic as repository of SCHIP and Medicaid materials.

- Provision of training on the benefits of insurance and the health coverage programs to school personnel, parents, and community groups. Many states report the development of state-customized exhibit displays that staff, such as the school nurses, use at parent meetings, back-to-school nights, school health fairs, and education association meetings.

- Inclusion of health insurance information within their curricular/teaching activities with students (e.g., health classes).

- Coordination with athletic directors to determine the insurance status of potential student athletes.

- Identifying uninsured students from health records and, in some cases, determining eligibility by consulting other school information, such as the school lunch application. Nurses share this information with Medicaid agency representatives. In some cases, nurses are the first point of contact with eligible families through mailings, telephone interviews, at-school appointments, or family visits. They are also available to

assist parents in filling out the applications available within their offices. Occasionally, they convey the applications to the enrolling agent/agency.

In two of the states interviewed, the school nurse was an eligible enrolling agent for SCHIP. That is, they have the authority from the enrolling agency to determine eligibility, assist with application completion, and enroll the student/family, on-site, in the coverage under SCHIP/Medicaid.

CHALLENGES TO SUCCESS

Although there are many materials and activities in current use promoting the SCHIP/Medicaid programs within schools, state education and Medicaid personnel interviewed were quick to note they have encountered many barriers to successful and consistent implementation of these strategies. The different governance structures of the Medicaid/SCHIP programs and



education often created barriers to successful implementation of strategies. CCSSO interviews found frustration among many of the state Medicaid personnel at the disconnect, or their own understanding of the

connections, between state and local education entities.

The differences in governance authority maintained or shared by state and local education agencies often seem to scuttle consistency of effort in disseminating and distributing SCHIP and Medicaid materials to all districts, schools, and ultimately to all school children. Both education and Medicaid interviewees described occasional incidences of allocations of SCHIP and Medicaid materials to school districts and buildings where, without implementation requirements, they sat undistributed. The SCHIP/Medicaid outreach coordinators in both agencies indicated they are almost universally dependent on the commitment,

or at very least the goodwill, of local school leaders to ensure information on SCHIP gets into the hands of school children and their parents.

The school lunch applications provide an additional example of the primacy of local educational authority. The USDA provides a prototype application for the school meals programs to state child nutrition administrators, predominantly in state education agencies. The states, in turn, modify or customize the prototype for their own state use, incorporating some of the SCHIP/Medicaid outreach tools delineated above, and then conveying the state prototype to the local school district. In many states, it is the local prerogative to use the state prototype or not. Indeed, some entities choose to exclude the health insurance provisions.

By contrast, school health cards are usually developed at the local level, but state education personnel responsible for SCHIP/Medicaid outreach often provide sample cards and encourage locals to incorporate insurance questions and information on the cards. Because state education health services personnel communicate frequently with the school nurses on issues related to SCHIP and Medicaid, the use of the health cards to disseminate messages on the insurance programs seems to be consistently applied throughout multiple districts.

The collection of data from these instruments—the school lunch form and the health cards—proves somewhat problematic. Even where the school superintendent and/or building principal are fully committed to expanding school outreach efforts, sometimes statewide, or even districtwide, data systems either do not exist or are not automated for easy retrieval (i.e. there is a will, but no way).

The check-off boxes on the school lunch form provide a salient example of the disconnect between state and local data retrieval mechanisms and the ensuing misunderstandings that may result among potential applicants to SCHIP. Both state education and Medicaid agency personnel interviewed cited examples of statewide inclusion of the requisite boxes on the school lunch forms; however, local authorities assigned no staff to specifically collect the information from the forms.

Those mentioning this disconnect surmised that it leads to a number of regrettable misconceptions among the parents who checked the boxes. For example, some parents assume that having checked the box, their children were automatically enrolled in the program. Those interviewed agreed, at the very least, parents who indicate they would like to receive additional information on the state's insurance support programs SHOULD have their request met. However, this is sometimes not the case.

Among the nearly 50 interviews conducted, there is no reported lack of proven materials for spreading the message on SCHIP and Medicaid. Both state education and Medicaid agency staff report three major barriers to successful outreach in schools. The first of these—related to materials and media—has been documented in the preceding section of this paper. In part, the first obstacle is closely linked to the two other barriers frequently articulated by those interviewed as hindering successful school-based outreach for SCHIP and Medicaid:

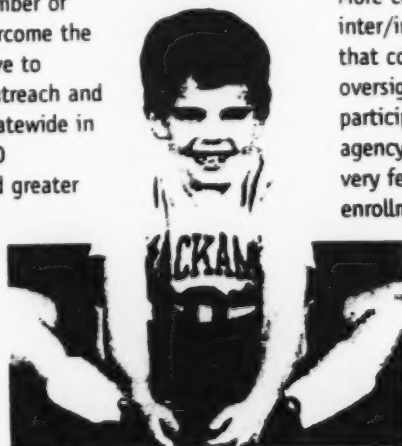
The lack of statewide systemic school-based infrastructure for the dissemination and collection of information on SCHIP and Medicaid

Inconsistent involvement in the programs at the local educational level

The need for a common language linking the education and health domains

PARTNERING TO OVERCOME CHALLENGES

States enlist a number of strategies to overcome the barriers highlighted above to broaden school-based outreach and enrollment, making it statewide in both the geographic AND systemic senses; to build greater public will among school leaders for the SCHIP and Medicaid programs; and to bridge the linguistic



gap between health and education. Chief among their means is collaborating with agency personnel and other experts who are connected with kids.

Partnerships for SCHIP outreach and enrollment in schools vary significantly by state, ranging from formal to informal, and differing in leadership, membership, and degree of activity. In a number of states, the leadership structure is housed within formal "Children's Cabinets" under the auspices of the state governor. These cabinets regularly convene heads of multiple state agencies, including education, health, human and social services, and juvenile justice—to name the most prevalent who oversee programs and services to children. Several interviews suggested that SCHIP and Medicaid activities are regular items on cabinet agendas.

Most significant of the activities cited for these leadership panels are joint communication of their membership on behalf of SCHIP. Examples of outreach activities include back-to-school kick-offs for SCHIP with governor and cabinet member appearances at media events; and joint letters promoting SCHIP in schools and among school children, sent over the signatures of cabinet members.

Similar letters signed just by the heads of the education and Medicaid oversight agencies (or occasionally by the governor and chief state school officer) were also noted. In their broadest use, such letters accompany the SCHIP information packages sent to all families of school children (either in the mail or sent home with students from school). Joint letters are also sent to district superintendents and/or school principals, enlisting or encouraging support for SCHIP/Medicaid outreach and enrollment in their schools.

More common than cabinet-level affiliations are inter/intra-agency committees or working groups that convene state agency personnel with direct oversight of children's programs. The staff participating in the interviews noted they are their agency's representatives on such collaborations. In very few cases, SCHIP/Medicaid outreach and enrollment is the sole objective of committee discussions. More frequently, the insurance programs are included among discussions

on an array of services delivered to children. Often, the level of activity is limited to information sharing.

In some cases (by no means all) these interagency groups are the same as, or build upon, statewide coalitions required by the state-grants programs under the Covering Kids Project supported by the Robert Wood Johnson Foundation. Every state receives a grant under the program, with broad-based coalition building in support of SCHIP as a primary objective. Interestingly, a number of state education personnel interviewed indicated their agency is not represented on their state coalition for Covering Kids.

State education and Medicaid agency representatives expressed the belief that such coalitions of program managers help to identify the nature and prevalence of barriers to school-based outreach, and provide opportunities to brainstorm on the means to overcome them. They are viewed as an instrument to build public will within state leaders, laying the groundwork for the statewide systemic infrastructure so badly needed. They also provide the medium for practicing and proving communications between the health and education disciplines.

However, interviewees stress that state coalitions are limited without the collaborative relationships established or developing at the local level to provide a more direct route beyond the roadblocks. That is, state affiliations for school-based outreach are most effective if they help their membership establish connections with regional and local education jurisdictions and the schools within them.

States use their coalitions to generate "buy-in" for SCHIP and Medicaid outreach and enrollment at the local level. As noted above, letters from public leaders (such as chief state school officers and/or governors) solicit the support of principals and superintendents for the programs. In several states, the letter requests that every principal designate an onsite staff person responsible for the dissemination and collection of information for the insurance programs within their schools. In a few states, local leaders within regions such as counties or school districts duplicate the media outreach events.



Outreach mailings and media events are mechanisms used to spread the word widely for SCHIP, but those interviewed clarify that forging lasting relationships at the local level—a more difficult task—is required to broaden the results. Medicaid and state education staff enlist a number of strategies to both inform and engage local school leaders in the task. Most frequently cited is the use of direct training by Medicaid and/or their local representatives.

Medicaid personnel stated they often present at statewide and regional associations of district superintendents, school principals, nutrition directors, school nurses, and athletic coaches. (They also generate interest in the exhibit halls with the SCHIP/Medicaid kiosks mentioned above.) Several states noted efforts to develop regular meetings of their county Medicaid outreach workers with the county's school nurses and other school personnel. School nurses are also called upon to address local meetings of principals, teachers, and parents about the SCHIP and Medicaid programs.

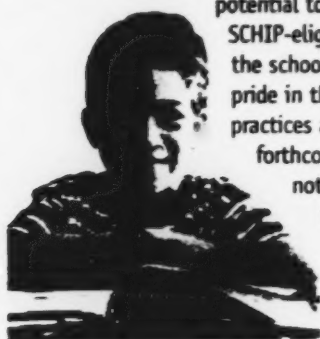
All of the discussions with state representatives focused on whom they hoped to engage as future partners in the outreach endeavor. The contacts highlighted prospective meetings with statewide, local, and school building parent groups, such as the PTA. Several noted targeting the medical community, most often pediatricians. Medicaid representatives mentioned their desire to engage other community-based organizations within schools. Several states noted the difficulty of reaching families and children who do not yet speak English. They hoped to find and work with local organizations that serve these communities and link them to their school partners.

WHAT STATES SAY THEY NEED TO SUCCEED

It should be highlighted here that several states have implemented incentive mechanisms to provide direct stipends to buildings where SCHIP enrollment increases are directly attributable to the school effort. In some cases,

these stipends accrue to the school's general fund, but most frequently they provide small incentives to the school health or nurse's office. For example, in one state a publishing company partner is providing gift certificates for every new SCHIP enrollee, to be used for purchases by the school's library. Interestingly, contacts spoke positively about such programs but felt their significance rested in the "recognition" that resulted for the program, not in the financial reward, since the funding levels were not of great scale.

As acknowledged in the opening of the report, the state education agency and Medicaid staff interviewed were uniformly enthusiastic about the



potential to reach and enroll SCHIP-eligible children through the schools. Interviewees voiced pride in their successful practices and programs, but were forthcoming that they were not consistently implemented throughout their states. They were circumspect that new resources—both fiscal and human—

would be welcomed and useful in this process.

In recognition of this, state contacts showed a keen interest in obtaining information on the successful practices implemented by other states and localities. They were generally enthused to participate in structured opportunities to learn from other state colleagues and experts.

THE ROLE OF THE STATE EDUCATION AGENCY

Staff from the multiple agencies represented were firmly convinced that children's health and education success are inextricably linked, and children at risk of school failure are often the same who experience health disparities. They expressed conviction that the education and health communities should be engaged in a substantive process to assure positive outcomes in both their domains, and the SCHIP program can and should play a part in that process.

These linkages are known intuitively, and are argued by anecdote, but staff interviewed expressed the need for research-based evidence to amplify the message. They seek successful testimony to provide to school leaders that links health coverage to positive health outcomes and consequent education outcomes. A language that translates these mutual objectives in a way that particularly engages school decision makers is needed.

Not all states interviewed indicated integral or thorough participation of the state education agency in extending the depth and breadth of SCHIP and Medicaid outreach and enrollment in schools. Virtually all specify such involvement as imperative for success, and the Medicaid staff asserted this in the strongest way. They know state education agencies have existing alliances to reach local education agencies, and they can help frame compelling messages showing the benefits of SCHIP and Medicaid coverage for school children.

States feel they could be most successful if they employ comprehensive outreach and enrollment strategies, involving multi-agency leadership. They voiced the need for aligned missions and objectives at the state level, targeted at stimulating systemic local initiatives. Medicaid agency outreach and state education agency health education professionals are natural allies in this effort.

Together they have identified principles that work and directions that seem promising. They should be offered continued and strengthened opportunities to join forces and take that creative path.



A CALL TO ACTION

There still is much to be done to strengthen and institutionalize school-based outreach and enrollment for SCHIP and Medicaid. As states, local districts, and schools are held more accountable for ensuring all children achieve to high standards, it is critical that children come to school healthy and ready to learn. State education agencies can step forward to work with state and local partners. In 1991 CCSSO identified several key roles that state education agencies can play in relation to school health programs. These roles are as valid today as they were then, and they are to

- 1 Demonstrate and encourage leadership
- 2 Provide support to enhance curriculum and instruction
- 3 Assure accountability for learning outcomes
- 4 Encourage active involvement of families
- 5 Strengthen partnerships

Over the past 15 years, we have seen the development of state education agency leadership in a variety of areas related to school health. In the building of school health programs, state education agencies have partnered with numerous entities, including state health departments, human service departments, and others. In addition, through guidelines, professional development, and technical assistance, states have supported local districts in developing their own school health programs. While these programs vary from state to state, they often share the common elements of (1) health education, (2) health services, (3) physical education, (4) healthful school environments, (5) counseling, psychological, and social services, (6) nutrition services, (7) parent and community involvement, and (8) health promotion for staff. Not surprisingly, many of these components can be used to promote access to SCHIP and Medicaid.

Such leadership, demonstrated by the states through activities that fall within these eight components of coordinated school health, can also be extended to school-based outreach and

enrollment activities for the SCHIP and Medicaid programs through the five key roles identified for state education agencies above. For example:

State education agency chiefs, deputies, and their health education, health services, and nutrition staff can demonstrate and encourage leadership on behalf of the SCHIP and Medicaid insurance programs throughout and across state agencies and particularly within and across school districts and schools.

State education agencies can provide support to enhance curriculum and instruction to include timely and useful information about SCHIP and Medicaid within the appropriate classroom and student service settings.

State education agencies can help draw the connections between insurance and access to the care provided by the SCHIP and Medicaid programs to assure health outcomes, and the state experience with coordinated school health programs can help strengthen the understanding that healthy students make better learners.

State education agencies can encourage active involvement of families in assuring the education success and the health of their children, and the relation of families to schools makes it a natural starting place to promote access to health care for children.

State education agencies can join with other agency partners to help schools focus attention and provide the multiple services that support students and families in order to assure academic success; the SCHIP and Medicaid programs can be a vital component in strengthening such partnerships.

State Medicaid and SCHIP agencies can and must reach out to their education counterparts as well. Through an enhanced or strengthened understanding of how state education agencies work to support districts and schools, they can harness the power of state education agencies.

Finally, all child-serving agencies can begin to think about the common outcomes that are desired for the children in that state and explore how collaboration, not competition, can support those outcomes.

APPENDIX 1

STATE EDUCATION AGENCIES CONTACTED

Alabama
Alaska
Arkansas
California
Connecticut
Delaware
Florida
Hawaii
Idaho
Illinois
Kansas
Maryland
Michigan
Minnesota
Missouri
Montana
New Hampshire
New Jersey
New York
Rhode Island
South Carolina
South Dakota
Texas
Utah
Vermont
West Virginia
Wisconsin

STATE MEDICAID AGENCIES CONTACTED

Alaska
Colorado
Delaware
Georgia
Hawaii
Idaho
Illinois
Kentucky
Maine
Massachusetts
Michigan
Mississippi
Montana
New Hampshire
New Jersey
North Dakota
Pennsylvania
South Carolina
Texas
Vermont

35 states represented
47 interviews conducted
27 SEA interviews
20 Medicaid interviews
12 states had both agencies interviewed

APPENDIX 2

CCSSO/PACKARD SCHIP ADVISORY GROUP-June 6, 2001 Participants

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BARRY SACKIN

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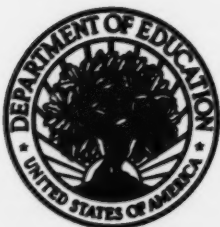
**The contents of this paper are solely the responsibility of the authors and do not necessarily represent the official views of this advisory panel.*



Healthy Kids Make Better Students
Better Students Make Healthy Communities

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